



**KAPI'OLANI  
MEDICAL CENTER  
FOR WOMEN & CHILDREN**



An affiliate of Hawaii Pacific Health

**ADULT VOLUNTEER APPLICATION**



Ronald McDonald House Family Room  
2nd floor, Kapiolani Medical Center for Women & Children  
Ph. (808) 983-8140  
FAX (808) 973-4753

**GENERAL INFORMATION**

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_  
Last First MI Month/Day  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Business): \_\_\_\_\_ (Cell): \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Emergency Contact Person: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone (H): \_\_\_\_\_ (B): \_\_\_\_\_ (C): \_\_\_\_\_  
Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever been convicted of a felony? Yes \_\_\_\_\_ No: \_\_\_\_\_ If yes, explain when, where, type of offense and disposition of case. (A conviction will not necessarily disqualify applicant from the position applied for.) \_\_\_\_\_

***A Criminal Background Disclosure will be conducted as part of the application process.***

**Health Insurance Portability and Accountability Act**

I, \_\_\_\_\_, have given RMHC the authorization for the use, request, and release of my confidential health information in regards to the Health Insurance Portability and Accountability Act (HIPAA).

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Official Use Only**

TB: (1) \_\_\_\_\_ (2) \_\_\_\_\_ or X-Ray: \_\_\_\_\_ MMR: \_\_\_\_\_ Chx Pox: \_\_\_\_\_ HepB: \_\_\_\_\_

BG Ck submitted: \_\_\_\_\_ BG Ck received: \_\_\_\_\_ Orientation Date: \_\_\_\_\_ Start Date: \_\_\_\_\_

**OTHER INFORMATION**

Current Employer: \_\_\_\_\_ Position/Title: \_\_\_\_\_

School: \_\_\_\_\_ Major: \_\_\_\_\_

Work experience (paid or volunteer):  
\_\_\_\_\_  
\_\_\_\_\_

Career/special interests, hobbies, skills:  
\_\_\_\_\_  
\_\_\_\_\_

List special training or noteworthy achievements:  
\_\_\_\_\_  
\_\_\_\_\_

**REFERENCES**

Name three individuals (not related) who have knowledge of your qualifications and whom we have permission to contact immediately, preferably individuals under whom you have worked.

Name	Title/Occupation	Where Employed	Business Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**AVAILABILITY**

Days/Times you are available to volunteer? Please check below (Minimum 4 hours per shift):

9am-1pm  
Mon \_\_\_\_\_ Tues \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_

1pm-5pm  
Mon \_\_\_\_\_ Tues \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_

5pm-9pm  
Mon \_\_\_\_\_ Tues \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_

Check if interested to be On-Call \_\_\_\_\_ (Need to be available from 9am-9pm for last minute cancellations)

I certify that the information in this application is true and correct to the best of my knowledge. I give consent to my current and previous employers and persons given as references to respond to verbal or written requests for further information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Hawaii Pacific Health

Kapi'olani • Pali Momi • Straub • Wilcox

### **ADULT VOLUNTEER HEALTH REQUIREMENTS**

The following forms and/or documentation must be completed and received prior to Volunteer Orientation:

- Application
- Two negative TB test results (one within the current year and one within 90 days of volunteer service start date) OR
- An x-ray if you had a positive TB, along with documentation (date and size) of the positive reading.
- Rubeola (measles) titre blood test.
- Rubella titre blood test.
- Chicken pox (Varicella) titre blood test.
- Hepatitis B immunizations (series of 3 shots) or a signed Declination form (available from the Volunteer Office).
- Hawaii Pacific Health (HPH) Background Request Form

**TB and X-rays may be taken at:**

- Lanakila Health Center Phone: 832-5731 Information Line: 832-5738  
1700 Lanakila Avenue, Honolulu, HI 96817  
Office hours are: Mon, Tue, Wed & Fri: 7:45 AM to 12:00 PM and 1:00 PM to 3:00 PM  
Thu: 7:45 AM to 12:00 PM and 1:00 PM to 2:00 PM (No testing; readings only)

**TB and Titre blood tests may be taken at the following locations:**

**IMPORTANT NOTE: You must contact the Volunteer Office at 983-8281 to obtain the required paperwork **BEFORE** going to the following Employee Health Offices:**

Kapi'olani Medical Center at Pali Momi  
Employee Health Services

Phone: 485-4123

Office hours are: Tuesdays from 7:30 AM to 11:00 AM in Pre-admission Education Rm (2<sup>nd</sup> Fl.)  
Thursdays\* from 1:00 PM to 4:00 PM in Pre-admission Education Rm (2<sup>nd</sup> Fl.)  
\*Readings only; no testing.

- Kapi'olani Medical Center for Women and Children Phone: 983-8525  
Employee Health Services, Bingham Building-1<sup>st</sup> Floor  
Office hours are: Mondays from 7:30 AM to 10:30 AM  
Tuesdays from 12:30 PM to 3:30 PM  
Wednesdays from 7:30 AM to 9:30 AM  
Thursdays from 12:30 PM to 3:30 PM (**READINGS ONLY**)  
Fridays from 7:30 AM to 10:30 AM

- Straub Clinic and Hospital Phone: 522-3481  
Employee Health Services, 888 S. King Street, Milnor, 1<sup>st</sup> Floor  
Office hours are: Monday through Friday 7:30AM-8:30AM  
\*Thursdays no testing; readings only.  
\*Appointments available by calling 522-3481.

**For further information please call Volunteer Services at 983-8281, Mon- Fri, 8:00 AM to 4:00 PM**



# Hawaii Pacific Health

Background Request Form

Personal Information...Print capital letters in the boxes. Try not to touch the sides of the boxes.

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

First Name

Middle Name

Last Name

Previous Legal Name

Year Changed

Street Address

City

State

ZIP

Social Security Number

Date of Birth (month-day-year)

Driver's License Number

State

### Previous Addresses...Most Recent First

City

State

ZIP

City

State

ZIP

City

State

ZIP

City

State

ZIP

Client Name (Requester)

Account #

Location

Voice Telephone Number

FAX Telephone Number

SSN->

Felony->

NCRF->

I have read, understood and agree to the following: The background information that I supply in connection with my employment application will be verified by Hawaii Pacific Health; ChoicePoint Services Inc.; and mutual associations to insure that the information that I provide is accurate in every way. The information to be verified includes any and all information supplied on any application form or resume, and information provided in any conversation or interview with any employee of Hawaii Pacific Health. This may include discussions with references (personal or business) that I provide. I authorize Hawaii Pacific Health and its agents to conduct a thorough inquiry into all areas deemed necessary to arrive at a hiring decision: all employment, educational, driving, credit reports and criminal public record information relating to my application may be examined. I specifically release former employers, criminal information repositories and courts, schools, law enforcement agencies, local, personal and professional references and credit bureaus from any liability so that they may freely and completely respond to any inquiry relating to my application for employment with Hawaii Pacific Health.

Signed \_\_\_\_\_

Date \_\_\_\_\_

FOR VOLUNTEER OFFICE USE:

Date Submitted: \_\_\_\_\_

KMCWC

KMCPM

Straub

RMH

HT/Reiki

MOD